Cambridgeshire Community Services NHS Trust

TRUST BOARD

Title:	**QUALITY REPORT**
Action:	**FOR DISCUSSION, NOTING AND APPROVAL**
Meeting:	**WEDNESDAY 12 SEPTEMBER 2018**

Purpose:
This report gives an overview of Quality related areas of practice and an opinion regarding the level of assurance that the Board can take from the underpinning information. The assurance opinion categories reflect those utilised in the Internal Audit Programme, namely substantial, reasonable, partial or no assurance.

Key risks related to each subject area are identified and mitigation actions highlighted. These areas of risk are identified, recorded on the Risk Register, managed and escalated where appropriate.

The report is supported by a data pack covering the period June and July 2018 (with any relevant key current updates) and is focused on the CQC five Key Lines of Enquiry. The information is triangulated with our clinical services to ensure a holistic judgement is made.

Detailed local analysis of quality performance is undertaken within the 3 Clinical Operational Boards and points of escalation reported to the Board.

Recommendation:
The Board is asked to:

Note the information in this report with additional information relating to the recent GMC survey results and Learning from Deaths.

Approve the Winter Plan and EPRR Core Standards self assessment both recommended for approval by the Board from the Quality Improvement and Safety Committee.

	Name	Title
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Trust Objectives

Objective	How the report supports achievement of the Trust objectives:
Provide outstanding care	The data pack demonstrates a good understanding of quality across the organization
Collaborate with other organisations	A number of sections reference collaboration with relevant partners and stakeholders
Be an excellent employer	Staffing pressures are escalated using our early warning trigger tool and managed at an early stage by teams to prevent negative patient impact. This report highlights a focus on safe staffing, related risks and mitigating actions. A number of staff engagement activities are highlighted which demonstrate an increased focus on this area of support.
Be a sustainable organisation	Patient feedback is consistently high and where concerns are identified, learning is identified and improvements to practice made.

Trust risk register
This report refers predominantly to actions associated with Board risk 1320 relating to maintenance of compliance with CQC standards. Individual sections have associated risks that are monitored by Clinical Operational Boards.

Legal and Regulatory requirements:
All CQC Key Lines of Enquiry and fundamental standards of care are addressed in this report.

Previous Papers:

Title:	Date Presented:
Trust wide Board Quality report & Data Pack / appendices	July 2018

Equality and Diversity implications:

Objective	**How the report supports achievement of objectives:**
Achieve an improvement in the percentage of service users who report that they are able to access the Trust services that they require	Compliance with the 18 week Referral to Treatment target is included in the Responsive section of the supporting data pack.
To introduce people participation in our diversity and inclusion initiatives to capture the experience of hard to reach/seldom heard/varied community groups.	Examples of patient and service user engagement continue to be highlighted in the data pack. Section 9 notes that actions from year 1 of our revised Quality & Clinical Strategy including People Participation are reported in a separate paper outlining progress with all strategies underpinning our 5 year plan to this Board .
To introduce wider diversity on recruitment selection panels.	Not included in the report this time
To deliver customised training and development for staff to further improve awareness of diversity and inclusion.	Not included in the report this time

Are any of the following protected characteristics impacted by items covered in the paper – No

Age	Disability	Gender Reassignment	Marriage and Civil Partnership	Pregnancy and Maternity	Race	Religion and Belief	Sex	Sexual Orientation
☐	☐	☐	☐	☐	☐	☐	☐	☐

1. EXECUTIVE SUMMARY / KEY POINTS

1.1 The Board can take Substantial assurance overall from the data presented and consideration of the systems and processes in place to support the delivery of high quality care. This is supported by the information referenced throughout this report from Appendix 1 (Quality Data Pack for June and July 2018). The receipt of a positive summary report from a recent external review into our governance and risk process, provides further assurance relating to the well Led section. There were no significant concerns raised regarding the Trust's controls upon which we rely on to manage our identified risks.

1.2 Key points:

1.2.1 Two Serious Incidents (SIs) were reported in July. One related to wrong teeth extraction in Dental services and has met the criteria for a Never Event. An external expert review of the Never Events reported from this service has been commissioned. The second SI was reported from our Norfolk 0-19 service and relates to missed opportunities to escalate safeguarding concerns. These incidents are currently being investigated.

1.2.2 A focus on safe staffing is highlighted in section 2.5. This identifies those services which are experiencing continued staffing pressures and the mitigating actions to keep patients and staff safe.

1.2.3 The Board will note a summary of progress with the Health Service Safety Investigations Body legislation in section 2.6 and that further updates will be brought to the Board's attention when available.

1.2.4 Mandatory training compliance has dipped overall to 92% which although at target, has reduced since the last report due to the initial reporting in July from Bedfordshire services with reduced compliance levels. Plans are in place to address this.

1.2.5 Section 5.1 highlights the 100% compliance for 3 months of the 25 (standard) and 30 day (complex) complaints response times.

1.2.6 Breaches of the 18 week RTT are outlined in section 5.2 with mitigating actions and plans overseen by the Clinical Operational Boards.

1.2.7 Section 7 informs the Board of the recent positive results from the GMC survey of Trainee doctors.

1.2.8 Our Q1Learning from Deaths report is highlighted in section 8 with full details in Appendix 4.

1.2.9 Section 9 sumarises key points from our Quality Improvement and Safety Committee (QISComm) including the recommendation that the Board approves both the annual winter plan and EPRR self assessment.

1.3 There are no indications of significant breaches of CQC fundamental standards.

2. Assurance opinion

The Board can be offered ***Reasonable*** assurance overall that patients are kept safe and protected from harm due to the following information:

2.1 *Management of patient safety incidents (including Information Governance)*

2.1.1 Two Serious Incidents (SIs) were reported during July.

- The first involved extraction of deciduous teeth under general anaesthetic. The teeth were wrongly recorded on the consent form and were removed in error.
- This incident has met the criteria for a Never Event and we have therefore commissioned an external expert review of previous Never Events within our Dental services to ensure that all appropriate learning and actions have been identified and undertaken. The review will also examine the high risk elements of dental services to ensure that we have all appropriate systems and processes in place to maximize patient safety.
- The Clinical Lead (Head of Dental Healthcare) presented a comprehensive update of actions identified following the recent CQC visit to the August Clinical Operations Board and reflected the many completed actions and remaining outstanding actions due for completion by November 2018.

- The second Serious Incident involved a failure to escalate safeguarding concerns to an appropriate agency within our 0-19 service in Norfolk. This is currently under investigation.

2.2 *Safeguarding*

2.2.1 Page 4 of the Data Pack highlights continued Trust wide compliance with Home Office targets for Prevent training with Basic Awareness at 85%. WRAP training compliance is at 83% (national Home Office target 85%) due to the integration of Bedfordshire services –the previous employer had ceased to record any mandatory training for the 3 months up to the point of transfer in April and there was very little evidence of completion available.Staff have been updating their training since April with CCS and full compliance is anticipated by the end of September.

2.2.2 Children – Safeguarding Children level 3 training compliance improved overall in June to the target of 92% but dipped to 90% in July. Norfolk and Luton 0-19 teams dropped to 90% and 91% respectively due to staff sickness, service pressures and an agreement in Luton to wait for the revised training in August which reflects new priorities. Paediatric Medical staff are being targeted on Holly Ward. Compliance also includes Bedfordshire staff from July whose compliance is at 79%.

2.2.3 Supervision compliance was maintained at 95%. Progress is monitored through the Clinical Operational Boards.

2.3 *Infection Prevention and Control*

2.3.1 Page 7 of the data pack notes that the Trust's staff Influenza vaccination programme plans have been approved by the IPaC Committee with an ambitious target to achieve 80% of front line staff vaccinated by the end of the campaign as

this is the 80th anniversary of the development of the first Flu vaccine. This is against a national target of 75%. Our programme will include a number of incentives for staff and vaccinators including for the first time, an initiative to donate vaccines to underdeveloped countries through Unicef for every vaccine given to staff (including those who notify us that they have received the vaccine elsewhere i.e GPs).

2.3.2 A number of areas that have achieved the national cleaning contract compliance thresholds have noted concerns about overall cleanliness in their areas. This is being monitored by the IPaC Matron and actions taken locally where specific actions are required. The impact is monitored by the Infection Prevention & Control Committee.

2.4 ***Safety Thermometer – Luton (dashboard page 23 data pack)***

2.4.1 The overall harm free result has improved in June (92.5%) and July (93.8%) from May's result of 88%.

2.4.2 The new harm metric is more indicative of the care directly provided by our staff and this increased to 97.96% in July (target 98%). The Bedfordshire & Luton Clinical Operational Board continues to oversee this metric.

2.5 ***Safe Staffing***

2.5.1 The Board can be offered ***Reasonable*** assurance that patients are kept safe and protected from harm due to the following information related to staffing:

2.5.2 Staffing pressures continue in a number of services with detailed oversight by the Clinical Operational Boards. The sections below identify current areas under most pressure and the mitigating actions that are being taken to maintain both patient and staff safety. This includes, as previously reported, use of bank and agency staff and a variety of approaches to recruitment. Where relevant, Quality Early Warning Trigger Tool scores are highlighted.

2.5.3 **Luton Unit**

2.5.3.1 Community Paediatrics continue to experience the same challenges as previously reported in service delivery due to increased demand and staffing pressures. The breaches in 18 week waiting time continue and the risk has been scored at 15 due to increasing referrals. The QEWTT score reduced to 11 in July due to reduced numbers of complaints and improved IT provision. The score is predicted to rise in September as Schools return and complaints about access from this source of referral resume.
The Clinical Operational Board received an update in August regarding the agreed additional funding of £310,000 from commissioners and a number of actions that are in process which should positively impact the waiting time for appointments.
Appropriate clinical prioritisation of children receiving controlled medication has continued.
A system wide event was held in July to look at the ASD pathway and redesign the service to meet demand. This was facilitated by CCS Service Redesign team, chaired by Bedfordshire Commissioners and attended by most relevant partners and representatives from parent carers' forums.

2.5.3.2 The Audiology service continues to report 6 week diagnostic breaches with problematic access to locum and bank staff resulting in an increased QEWTT score to 15 in July from 9. The Enhanced Support Worker role has been successfully introduced to the team with a focus on delivering assessments. Joint posts are being considered with Bedford and Luton Hospitals. All actions continue as previously reported.

2.5.3.3 Luton 0-19 teams continue to experience pressures due to significant vacancy factors (6.5 vacancies in Health Visiting and 2 in School Nursing). Additional funding has been received from Early Help services for health Visitors to undertake a holistic family assessment at the ante natal visit. This requires 2.5 additional HVs and although there has been some internal movement of staff, other posts are being filled by less experienced staff requiring additional support and guidance.
Redesign plans for the 5-19 service include adopting the CHATHEALTH model of contact and developing a single point of contact approach agreed with commissioners.

2.5.3.4 Luton adult services pressures have been reported from the Nightingale District Nursing cluster with a QEWTT score of 18 due to staff sickness and recruitment difficulties. A number of mitigating actions are being undertaken.

2.5.4 **Bedfordshire Children's services**

2.5.4.1 The Continuing Care Team have experienced significant staffing pressures which have led to cancellation of visits. Families were fully informed of the situation and where possible, mitigating actions put in place. There is inadequate bank and agency provision due to the complexity of care needs and has been no capacity available within our other teams across our portfolio to support at this time. The associated risk is scored at 12 with a QEWTT of 19.

2.5.4.2 Speech and Language Therapy services have struggled to recruit and there have been breaches to the 18 week target. This service currently has a staffing risk of 12 and QEWTT of 23. The Clinical Operational Board received an overview of mitigating actions which include prioritization of dysphagia referrals and follow ups in community and schoolsettings. Caseload allocation meetings review clinical need of remaining cases.

2.5.4.3 The Single Point of Access for 0-19 service have challenges with staffing, estate and telephony. Local actions are being progressed to improve the working environment and longer term estates and telephony improvements are being considered. The service risk is at 16 with a QEWTT of 19.

2.5.5 **0 - 19 services (Cambridgeshire and Norfolk)**

2.5.5.1 The overall Cambridgeshire based 0 - 19 service report an expected improved position in staffing due to the successful recruitment of students following completion of their courses. Pressure points remain with the Cambridge City and South HV team and 5 - 19 team who have both reported QEWTT scores of between 16 - 24 for 2

consecutive months due to sickness and vacancies. Staffing levels continue to be monitored by senior service leaders on a weekly basis with a number of mitigating actions in place as previously reported.

2.5.6 **Norfolk**

2.5.6.1 Pressures with staffing in Norfolk based 0 - 19 teams continue with Business continuity plans in place for four localities where teams are unable to fulfill complete Healthy Child Programme commitments and therefore prioritise safeguarding cases and supporting the most vulnerable families.

2.5.6.2 Breckland, West and City Teams continue to report high QEWTT scores. Oversight of mitigating actions is undertaken at the Children and Young People Clinical Operational Board. Service plans for 2018 / 2019 include exploration of alternative ways of delivering universal mandated contacts from the Single Point Of Access and recruitment to skill mix posts to deliver increased Universal Plus activity within localities.

2.5.6.3 Staffing compliance on the Acute Paediatric unit is reported on page 8 of the data pack.

2.5.6.4 SCBU reports an improved staffing picture due to successful recruitment to its funded establishment and one occasion in July with restricted internal admissions.

2.5.6.5 Holly Ward reported 3 short periods of restrictions to admissions in July due to a number of reasons including patient complexity i.e more than one high dependency patient. There was no impact to patients reported.

2.5.7 **Ambulatory Care services**

2.5.7.1 iCaSH Bedfordshire staffing position is improving due to development of new roles i.e Associate Nurse Consultant and linking with iCaSH Peterborough to co train new staff.

2.5.7.2 As previously reported, Dental services continue to be challenged by staff sickness which has increased to 7.25% (rolling cumulative rate) in July from 5.97% in May. This has impacted on a number of workforce metrics including appraisal rate which has remained off target at 89.4%. Their QEWTT scores remain in mid range due to a number of mitigating actions including an increase in temporary staff.

2.6 ***Healthcare Safety Investigation Branch (HSIB) and plans to endorse HSSIB***

2.6.1 In 2017 a new, independent body was funded by The Department of Health and hosted by NHS Improvement aimed at ‘improving safety through effective and independent investigations that don’t apportion blame or liability’, and errors can be understood in context of both human factors and health care work environments.

This learning through improvement approach is supported by many of the organisations dealing with patient safety due to its positive aim to effect change at a wider level than where incidents occur.

The initial focus for the HSIB has been systematic reviews of maternity deaths which have been widened in a pilot programme of investigations into maternity and neonatal care.

2.6.2 One of the key principles for the HSIB is the concept of 'Safe Space'. This relates to a safe process for information to be shared which is non disclosable. There have been debates about the level of information that can be shared and a number of bodies have commented that this part of the underpinning legislation should be revised.

2.6.3 The Joint Committee on the Draft Health Service Safety Investigations Bill has met and endorsed the legislation's aim to conduct investigations that cover NHS providers of care as well as any setting of the pathway including social care and private providers. The new body Health Service Safety Investigations Body (HSSIB) expects the legislation to be approved by Parliament in the 2019 / 2020 Parliamentary cycle and the Government is reported to be considering a number of improvements to the Bill.

2.6.4 NHS providers provided an update to NHS Trusts in August relating to these suggestions which are welcomed in respect of providing clarity on levels of disclosure and the need for independent investigations conducted under the 'safe Space' process.

2.6.5 The Board will be updated as further developments occur that impact our services.

Effective

3. Assurance opinion

The Board can be offered ***Reasonable*** assurance that all elements of this Key Line of Enquiry are being actively managed.

3.1 ***Workforce metrics*** are outlined on page 9 of the data pack and assurance is based on the following:

3.1.1 Overall mandatory training compliance has remained above the 92% target at 96% for June and 93% in July. The inclusion of Bedfordshire staff in the overall metrics for the first time in July has dipped the overall rate as 10 out of 11 subjects are below target. This position has therefore also been reflected in the reporting of overall trust wide individual subject areas. As reported in section 2.21, recording of mandatory training attendance and compliance had ceased with their previous employer 3 months before transfer. Full compliance is anticipated by the end of September.

3.1.2 Individual service rates of compliance are monitored by the Clinical Operational Boards.

3.1.3 The percentage of appraisals has increased slightly to 90.28% against the target of 92%. Clinical Operational Boards have detailed oversight of remedial actions.

3.1.4 Sickness rates across services remain a challenge as previously reported. The rolling cumulative rate was reported as 4.99% in July which is the highest in the preceding 12 months. The principle reason cited by staff this period was gastrointestinal problems. Managers and HR staff continue to support teams with assisting staff to return to work safely after periods of illness.

Caring

4 Assurance opinion

The Board can be offered ***Substantial*** assurance that staff treat people with compassion, kindness, dignity and respect due to the following:

4.1 *Patient story*

The patient experience story due to be discussed with the Board at this meeting is being shared by our 0 - 19 service in Cambridgeshire and involves a mother's perception that there was a missed opportunity to support her desire to continue to breastfeed as there was delay in the diagnosis of the baby's tongue tie.

4.2 *Friends and Families Test (FFT)*

4.2.1 Results are highlighted on page 12 of the data pack including an overall score of 95.22% with all services receiving some feedback. Comments relating to negative scores are reviewed by teams and details are outlined in the Data pack.

4.2.2 A selection of positive comments received regarding our services is included in the data pack on page 11.

Responsive

5. Assurance opinion

The Board can be offered ***Reasonable*** assurance that servces are organised to meet people‘s needs beacuse of the following:

5.1 *Complaints*

5.1.1 Complaints information is outlined on pages 13 and 14 of the Data Pack and highlights the significant improvements made to the handling of complaints during 2018. 100% of all standard complaints were responded to within the 25 day timeframe along with 100% of the more complex investigations which have a timeframe of 30 days.

5.1.2 Seven of the complaints related to clinical care with no specific themes identified. A further 6 related to ‘staff attitude’ again with no particular trends. Work is underway to encourage a local resolution process for our services so that patients and service users are offered timely contact to resolve any issues as soon as possible with the formal complaints process as an option if appropriate.

5.1.3 Actions / learning from investigations are highlighted in the Trust’s Governance Log which is circulated weekly to members of the Leadership Forum to ensure appropriate oversight and monitoring by service leads. Themes are also shared on the staff intranet learning pages where a high level themed summary of all complaints is also highlighted.

5.2 *Access to our services* page 14 data pack

5.2.1 Our Clinical Operational Boards focus on 18 week compliance and their updates give details of remedial actions. Specifically, Luton & Bedfordshire Community Paediatrics and Bedfordshire therapy performance is highlighted in the Bedfordshire & Luton Clinical Operational Board report to the Board.

5.2.2 Six week waiting time breaches continue as previously reported with the Luton Paediatric Audiology service. Mitigating actions are outlined in section 2.5.3.2.

6. Assurance opinion

The Board can be offered ***Sustantial*** assurance that the leadership, management and governance of the organisation assures the delivery of high quality person centred care, supports learning and innovation and promotes an open and fair culture. The main strategic risk associated with this section is 1320 relating to maintaining CQC standards. This risk score was reduced to 4 following our recent CQC Inspection and positive external Well Led review of our governance and risk arrangements by Deloitte.

6.1 *Quality Early Warning Trigger Tool*

This established tool (summarised on pages 17 - 19 of the data pack) is based on a number of metrics that mainly relate to staffing pressures and the impact on quality when staffing is compromised. The details are covered in section 2.5 (safe staffing) of this report.

6.2 *Patient Engagement*

A number of examples of service improvements following feedback and patient engagement activity are included on page 20 of the data pack.

6.3 *Staff Engagement*

Page 21 of the data pack highlights the continued focus on staff engagement throughout June and July.

6.4 *Research*

6.4.1 A summary of our active participation in research studies is highlighted on page 22 of the data pack. Of note is the continued active involvement of our services in research activity. Appendix 2 is taken from the National Institute for Health Research (NIHR) Q1 report and highlights the 15% increase in recruitment to NIHR studies since Q1 last year.

6.5 *Quality Dashboard*

The Trust wide dashboard (pages 23 - 24 of the data pack) is underpinned by service level data which is utilised at both local and Trust level to give an overview of a number of areas of quality performance. These metrics have been used to inform analysis throughout the report.

7.0 *General Medical Council Survey*

7.1 The Trust scored highly, as in previous years, in the annual GMC survey of trainee doctors (who work within our paediatric services), with overall satisfaction rate the second highest in the East of England. No areas of concerns were identified, and 4 areas of excellent practice highlighted (see at Appendix 3, the letter from the Postgraduate Dean and related appendix 3 of the report).

7.2 The ongoing contribution of senior medical and nursing staff should be recognised in the Trust continuing to be seen as a provider of high quality medical education.

8.0. *Learning from Deaths*

A summary report was presented to the Quality Improvement and Safety Committee which highlighted key learning from our Q1 review of deaths. This continues to be a developmental area for CCS as previously reported, the national guidance relates

mainly to adults who die unexpectedly in an inpatient setting. Work continues to refine our approach and develop relevant systems to capture and disseminate learning. The full report is at Appendix 4.

9.0. ***Summary from Quality Improvement and Safety Committee***

9.1 The Committee met on 29 August 2018. There were no points for escalation at the time of the meeting.

9.2 The following items are for information:

- The Committee noted the 2 Serious Incidents reported during July (these are described in section 2.1.1), the actions taken, on-going investigations and external review of Dental Never Events.

- The Trust's annual Winter Plan was received with no material changes to last year except the addition of Bedfordshire services. The committee recommends the Plan for approval by the Board (Appendix 5.1).

- The Committee also received the Trust's EPRR self assessment against Core Standards signed off by our Operational Group and Trust's Accountable Emergency Officer (currently Chief Nurse) (Appendix 5.2 – the supporting evidence pack was presented to QIS Committee). It noted the assurance detailed for each of the 54 standards in the 10 Domains and the overall rating of substantial compliance due to full compliance with 49 / 54 and plans in place to complete the remaining 5. These relate to 2 Domains – Duty to maintain plans and Business Continuity. Actions in these 2 areas include testing of a number of plans i.e site lock down plans across our full estate (a programme of testing will be agreed in October following devising of test mechanism and will start with our 4 main freehold sites initially) and site specific Business Continuity plans which are due for completion by the end of September 2018. The annual Deep Dive exercise as part of this submission relates to Incident Control Centre's for this year's assessment. This involves assurance relating to set up, training, policy and guidance. This has been self assessed as compliant in the 8 standards outlined.

- The Information Governance Annual report 2017 / 2018 and recommendations for 2018 / 2019 was approved and the improved assurance related to data quality was noted.

- The Medicines Safety & Governance annual report was also received and approved.

- The Learning From Deaths Group provided a summary report, full details are included at section 8 of this report

- A 6 month summary of patient experience themes and learning was received with a focus on changes that services have made following patient feedback.

- The year 1 Quality & Clinical Strategy update was discussed and key points are included in a separate summary paper to this Board of implementation progress for supporting strategies to our 5 year plan.

10. RECOMMENDATION

10.1 The Board is asked to note the assurance given relating to each of the 5 Key Lines of Enquiry based Quality topic areas of this report and the actions being taken to address areas of concern.

10.2 The Board is also asked to note the positive report from the GMC relating to feedback from our Trainee Doctors.

10.3 The Board are asked to approve the Winter Plan and EPRR self assessment – both overseen and recommended by the Quality Improvement and Safety Committee.

End of report

APPENDICES

- Appendix 1 - Quality Data Pack
- Appendix 2 - Recruitment to NIHR research studies
- Appendix 3 - GMC Trainee Doctor report and appendix
- Appendix 4 – Learning from Deaths
- Appendix 5.1 – Winter Plan
- Appendix 5.2 – EPRR paper to QIS Committee